STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/22/2012	
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
	This visit was fo Complaints IN00 and IN00110303 Complaint IN00 Federal/state def allegations are ci Complaint IN00 Federal/state def allegations are ci Complaint IN00 Federal/state def	r Investigation of 0109996, IN00110070, 109996 - Substantiated. ficiencies related to the fited at F514. 110070 - Substantiated. ficiencies related to the fited at F441 and F514. 110303 - Substantiated. ficiencies related to the fited at F441 and F514. 21 and 6/22/12 000059 155697 00266560 nnie Bartelt, RN	F0000	DEFICIENCY)	DATE
	Total: 63				
	Census payor typ Medicare: 4 Medicaid: 55	pe:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 06/22	LETED
	REHABILITATION A	ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD SVILLE, IN 47129)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Other: 4 Total: 63					
	Sample: 8					
		es reflect state findings ace with 410 IAC 16.2.				
	Quality review c 2012 by Bev Fau	ompleted on June 27, alkner, RN				

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Event ID: LWXM11

Facility ID: 000059

If continuation sheet Page 2 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN	IG		06/22/	2012
NAME OF B	DOLUBED OD GUDDU ED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
	EHABILITATION A	ND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=E		NTROL, PREVENT					
	SPREAD, LINEN	งธ establish and maintain an					
	•	Program designed to					
		anitary and comfortable					
		to help prevent the					
		d transmission of disease					
	and infection.						
	(a) Infection Con	•					
	•	establish an Infection					
	Control Program						
		controls, and prevents					
	infections in the	t procedures, such as					
		be applied to an individual					
	resident; and	be applied to all illulvidual					
	•	ecord of incidents and					
	• •	s related to infections.					
	(b) Preventing S	pread of Infection					
		ection Control Program					
	determines that	a resident needs isolation to					
	prevent the spre	ad of infection, the facility					
	must isolate the						
	· '	ust prohibit employees with a					
		isease or infected skin					
		ect contact with residents or					
	disease.	ct contact will transmit the					
		oust require staff to wash their					
	· · ·	direct resident contact for					
		hing is indicated by accepted					
	professional prac						
	(c) Linens						
	` '	handle, store, process and					
		so as to prevent the spread					
	of infection.						
		ation, record review and	F04	41	What corrective action(s) wil	I	07/10/2012
	interview the fac	cility failed to ensure			be accomplished for those		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155697	A. BUII B. WIN			06/22/2	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ITTLE LEAGUE BLVD		
CLADK		ND SKILLED NURSING CENTER			SVILLE, IN 47129		
CLARK	CHABILITATION F	IND SKILLED NORSING CENTER		CLARK	3 VILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	infestation of sca	abies was tracked and			residents found to have beer	ו	
	monitored as par	t of the facility's			affected by the deficient		
	surveillance procedures for 1 of 2 facility				practice? ·Resident G negation	ve	
	episodes of infestation/treatment for				for scabies with skin scraping results for alleged deficient		
	_	ficient practice affected 4			practice ·Resident A negative	for	
		viewed related to scabies			scabies with skin scraping res		
					for alleged deficient practice		
		ample of 8. (Residents			·Resident H negative for scabi	es	
	G, H, A, and E)				with skin scraping results for		
					alleged deficient practice		
	Findings include	:			Resident E negative for scabi	es	
					with skin scraping results for alleged deficient practice Hov		
	During interview	on the Initial Tour on			other residents having the	'	
	6/21/12 at 10:15	a.m., the Assistant			potential to be affected by th	e	
		ing (ADON) indicated			same deficient practice will b		
		on containment with all			identified and what corrective		
		ed to the hall since the			action(s) will be taken? · All		
					residents have the potential to	be	
		hall were being treated			affected by the alleged deficie	nt	
		medication. The ADON			practice. Full skin sweep		
	indicated Reside	nt G recently had a			conducted by DNS/Designee of 7/1/12 to ensure all other skin	on	
	positive skin scr	aping indicating scabies			issues were identified and		
	was present, so a	all residents on the hall			addressed. · Licensed Nursin	a l	
	were being treate	ed for possible scabies.			staff will be re-educated on or		
	She indicated so	me employees also had			7/3/12 on infection control and	,	
	been treated for				skin conditions tracking by the		
	Stem monitor for				DNS/designee. Post test		
	On 6/21/12 of 12	:15 n m rasidants wara			included. · Re-education on	.	
		2:15 p.m., residents were			infection control programs incl but not limited to: daily	uae	
		lunch in the dining room			surveillance log, individual rep	ort	
		Resident A was seated in			worksheet, monitor residents f		
		the table. The resident			change, monthly nosocomial		
	rubbed his hands	s together, interlacing the			infection report, complete facil	ity	
	fingers and twist	ing them back and forth,			map with key. In servicing will		
	~	e top of the thighs and the			take place on or by 7/10/12.		
	groin area.	. 5			Non-compliance with these		
	5.0 u.vu.				practices will result in further	,	
			1		education including disciplinar	у	

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CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER CN4)ID PREFIX TAG During interview on 6/21/12 at 12:20 p.m., Resident H indicated about six wecks ago she went to the dermatologist, and he said she had seabies. She indicated she itched all over, especially at night, "driving me nuts." She indicated she had red splotches all over her back, bottom side, and neck. 1. The clinical record for Resident H was reviewed on 6/21/12 at 12:30 p.m. The record indicated a consultative office visit to the dermatologist on 3/19/12. The dermatologist's note indicated, "Physician ExaminationHead, neck, upper chest, back, and upper and lower extremities reveal xerosis and excoriation. Close examination reveals evidence of burrow infestation. We have done a wet knot today and confirmed scabicctic activity in the form of live mites. Assessment: Scabies infestation. Plan: Nursing home authorities have been notified. The patient is going to be treated with Elimite [seabicidal medication] cream" 2. The clinical record for Resident G was reviewed on 6/21/12 at 2:00 p.m. Physician telephone orders, dated 3/20/12, indicated the resident was to	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 06/22/2012		
CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER SUMMANY STATEMENT OF DETICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) During interview on 6/21/12 at 12:20 p.m., Resident H indicated about six weeks ago she went to the dermatologist, and he said she had scabies. She indicated she had red splotches all over her back, bottom side, and neck. 1. The clinical record for Resident H was reviewed on 6/21/12 at 12:30 p.m. The record indicated a consultative office visit to the dermatologist on 3/19/12. The dermatologist's note indicated, "Physician Examination:Head, neck, upper chest, back, and upper and lower extremities reveal xerosis and excoriation. Close examination reveals evidence of burrow infestation. We have done a wet knot today and confirmed scabiectic activity in the form of live mites. Assessment: Scabies infestation. Plan: Nursing home authorities have been notified. The patient is going to be treated with Elimite [scabicidal medication] cream" 5. The clinical record for Resident G was reviewed on 6/21/12 at 2:00 p.m. Physician telephone orders, dated 3/20/12, indicated the resident was to 5. The clinical record for Resident G was reviewed on 6/21/12 at 2:00 p.m. Physician telephone orders, dated 3/20/12, indicated the resident was to			155697	B. WING		06/22/2012
During interview on 6/21/12 at 12:20 p.m., Resident H indicated about six weeks ago she went to the dermatologist, and he said she had seabies. She indicated she tiched all over, especially at night, "driving me nuts." She indicated she had red splotches all over her back, bottom side, and neck. 1. The clinical record for Resident H was reviewed on 6/21/12 at 12:30 p.m. The record indicated a consultative office visit to the dermatologist on 3/19/12. The dermatologist's note indicated, "Physician ExaminationHead, neck, upper chest, back, and upper and lower extremities reveal xerosis and excoration. Close examination reveals evidence of burrow infestation. We have done a wet knot today and confirmed scabiectic activity in the form of live mites. Assessment: Scabies infestation. Plan: Nursing home authorities have been notified. The patient is going to be treated with Elimite [scabicidal medication] cream" 2. The clinical record for Resident G was reviewed on 6/21/12 at 2:00 p.m. Physician telephone orders, dated 3/20/12, indicated the resident was to PREFIX TAG action. Director of onursing services/designee is responsible to ensure ompliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?-Full skin sweep conducted by DNS/Designee on 7/1/12 to ensure all other skin issues were identified and addressed Licensed Nursing staff will be re-educated on or by 7/3/12 to infection control and skin conditions tracking by the DNS/designee. Post test included Re-education on infection control programs include but not limited to daily surveillance log, individual report worksheet, monitor residents for change, monthy nosocomial infection report, complete facility map with key. In servicing will take place on or by 7/10/12. Non-compliance with these practices will result in further education including disciplinary action Director of nursing services/designee is responsible to ensure control and skin conditions tracking by the	CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	517	'N LITTLE LEAGUE BLVD	
p.m., Resident H indicated about six weeks ago she went to the dermatologist, and he said she had scabies. She indicated she itched all over, especially at night, "driving me nuts." She indicated she had red splotches all over her back, bottom side, and neck. 1. The clinical record for Resident H was reviewed on 6/21/12 at 12:30 p.m. The record indicated a consultative office visit to the dermatologist's note indicated, "Physician Examination:Head, neck, upper chest, back, and upper and lower extremities reveal xerosis and excoriation. Close examination reveals evidence of burrow infestation. We have done a wet knot today and confirmed scabiectic activity in the form of live mites. Assessment: Scabies infestation. Plan: Nursing home authorities have been notified. The patient is going to be treated with Elimite [scabicidal medication] cream" 2. The clinical record for Resident G was reviewed on 6/21/12 at 2:00 p.m. Physician telephone orders, dated 3/20/12, indicated the resident was to services/designee is responsible to ensure that the deficient practice does not recur?-Full skin sweep conducted by DNS/Designee on 7/1/12 to ensure all other skin issues were identified and addressed. Licensed Nursing staff will be re-educated on or by 7/3/12 on infection control and skin conditions tracking by the DNS/designee. Post test included. Re-education on infection control programs include but not limited to: daily surveillance log, individual report worksheet, monitor residents for change, monthly nosocomial infection report compliance, what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?-Full skin sweep conducted by DNS/Designee on 7/1/12 to ensure el dhere-skin issues were identified and addressed. Licensed Nursing staff will be re-educated on or by 7/3/12 on infection control and skin conditions tracking by the DNS/designee. Post test included. Re-education on infection control programs include but not limited to: daily surveillan	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
receive treatment with a scabicidal medication, and repeat the treatment in seven days. on skin assessments and infection control weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter.		p.m., Resident H weeks ago she wand he said she hindicated she itch night, "driving make had red splot bottom side, and had red splot bottom side, and had reviewed on 6/2 record indicated to the dermatologist's remaination Had back, and upper reveal xerosis and examination r	ent to the dermatologist, and scabies. She med all over, especially at me nuts." She indicated sches all over her back, neck. ecord for Resident H was 1/12 at 12:30 p.m. The a consultative office visit gist on 3/19/12. The mote indicated, "Physician lead, neck, upper chest, and lower extremities dexoriation. Close eals evidence of burrow have done a wet knot med scabiectic activity in mites. Assessment: on. Plan: Nursing home been notified. The obe treated with Elimite cation] cream" ecord for Resident G was 1/12 at 2:00 p.m. one orders, dated d the resident was to bing to rule out scabies, t with a scabicidal		services/designee is respons to ensure compliance. What measures will be put into pl or what systemic changes who be made to ensure that the deficient practice does not recur? Full skin sweep conducted by DNS/Designee 7/1/12 to ensure all other skir issues were identified and addressed. Licensed Nurs staff will be re-educated on o 7/3/12 on infection control an skin conditions tracking by the DNS/designee. Post test included. Re-education on infection control programs incompared but not limited to: daily surveillance log, individual reworksheet, monitor residents change, monthly nosocomial infection report, complete fact map with key. In servicing with take place on or by 7/10/12. Non-compliance with these practices will result in further education including disciplinal action. Director of nursing services/designee is respons to ensure compliance. How corrective action(s) will be monitored to ensure the deficient practice will not refice, what quality assurance program will be put into plated DNS/Designees will do audition skin assessments and infection control weekly x 4, bi-weekly x 2 months, monthly	on o

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PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S COMPLI		
ANDILAN	OF CORRECTION	155697		LDING	00	06/22/	
		100097	B. WIN			00/22/	2012
NAME OF P	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE		
CLVDKE	DEHARII ITATIONI A	ND SKILLED NURSING CENTE	D		ITTLE LEAGUE BLVD SVILLE, IN 47129		
			· · · · · · · · · · · · · · · · · · ·		SVILLE, IN 47 129	ı	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110	ALGOLATORI OR			1110	Findings from the CQI proces	s	D.T.E
1	3 The clinical r	ecord for Resident A was			will be reviewed monthly and		
	reviewed on 6/22				action plan will be implemente	ed	
		one orders, dated			for thresholds below 95%.		
		ed the resident was to					
		oing to rule out scabies,					
		t with a scabicidal					
		repeat the treatment in					
	seven days.						
	1 The clinical r	ecord for Resident E was					
	reviewed on 6/22						
		one orders, dated					
	1 -						
		ed the resident was to					
	_	oing to rule out scabies,					
		t with a scabicidal					
		repeat the treatment in					
	seven days.						
	On 6/22/12 at 10	2:45 a.m., the facility's					
		t provided the facility's					
		ection Reports for January					
		12. During interview at					
		licated reports for June					
	· · · · · · · · · · · · · · · · · · ·	et completed. The report					
		indicated four infections					
	related to skin, a	nd further information					
	· ·	of the four infections					
	was requested.						
ı	During interview	on 6/22/12 at 12:00					
ı	_	's Nursing Consultant					
	1	_					
		Nursing indicated they					
	nad spoken with	the nurse who completed					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/22/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129	1	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Infection Reports. They		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated the prorelated to scabies tracked on the Ni Report. They indicompleting the formation of the scabies as an infection. The facility's policy and infection. The proceduct conference room 11:15 a.m. The preview information infections: Culture pertinent lab data Daily Surveilland Individual Report formMonitor in changeMonthl Infection Report map - color code agenda items for Prevention CommeetingQuarted Quality Improve (Reviewed 12/20)	blems in March 2012 s infestation had not been osocomial Infection dicated the nurse orm did not consider ection. They indicated d have been tracked as icy for Surveillance re was provided on the table on 6/22/12 at policy indicated, "Daily on related to possible re report(s) and/or aDaily document on ce LogInitiate t Worksheet residents for y complete Nosocomial formComplete facility aMonthly prepare Infection Control and mittee erly complete Continuous ment Activities. 011)." relates to IN00110070					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 22/2012		
CLARK R		AND SKILLED NURSING CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	ATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPLI	ETED
		155697	A. BUII B. WIN			06/22/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			ITTLE LEAGUE BLVD		
	DELIADII ITATIONI A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
CLARK R	REHABILITATION A	IND SKILLED NORSING CENTER		CLARK	SVILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=E	RES						
		MPLETE/ACCURATE/ACCE					
	SSIBLE						
	-	maintain clinical records on					
		accordance with accepted					
	•	ndards and practices that are at a same a					
	•	systematically organized.					
	accessible, and	systematically organized.					
	The clinical reco	rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
	care and service	s provided; the results of any					
	preadmission sc	reening conducted by the					
	State; and progre	ess notes.					
	Based on record	review and interview, the	F05	14	What corrective action(s) will	i	07/10/2012
		ensure physician's orders			be accomplished for those		
	•	accurately, and that a			residents found to have beer	1	
		•			affected by the deficient		
		nistered on an as needed			practice? ·Resident F no long		
	basis was docum	ented on the medication			resides in the facility. ·Reside		
	administration re	ecord. The facility also			negative for scabies upon skin		
	failed to ensure d	locumentation related to			scraping results. Physician or	der	
	skin assessments	and skin scrapings for			was followed through and	_	
		g was complete and			resident received treatment for rash. Resident A treated for		
		eficient practice affected			scabies with no further sympto	me	
		-			of scabies. Resident C negat		
		whose records were			for scabies upon skin scraping		
	reviewed related	to complete and accurate			and physician order to treat wa		
	documentation.	(Residents F, E, A, and			followed through. How othe		
	C)				residents having the potentia	ıl	
	,				to be affected by the same		
	Findings include				deficient practice will be		
	i mamas merade	•			identified and what corrective	e	
	1 001 1: : 1	10 0 11 15			action(s) will be taken? · All		
		ecord for Resident F was			residents have the potential to		
	reviewed on 6/21	1/12 at 2:15 p.m. The			affected by the alleged deficien	nt	
	record indicated	the resident was admitted			practice. · Charge		
	to the facility on	5/22/12 after			nurse/Designee will conducted		

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE A. BUILDING			ETED
		155697	B. WING			06/22/	2012
		AND SKILLED NURSING CENTER		517 N LI	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
	hospitalization. History and Phy included, but we "coronary artery coronary artery post current isch presented with th hand pain with a [name of physic ischemic cardion fraction showed non-ST myocard and left bundle th hospital physicia Medication Rece included, but wa "Nitroglycerin s Nitrostat, 0.4 mi every 5 minutes chest pain." The facility phys upon admission indicate an order needed for chest Resident Progres 7:24 p.m., indicate complaining of o New order for N q [every] 5 min exceed 3 doses	Diagnoses on the hospital sical, dated 5/7/12, are not limited to, disease, status post bypass graft and status are mic attack that has the bilateral arm pain and a patent cath [catheter] per fian] and as per his wife; megaly with ejection 25 to 30%; hypertension; dial infarction previously; branch block. The finds Discharge/Home fonciliation, dated 5/21/12, as not limited to, sublingual tab: ordered as: alligrams, sublingual, PRN [as needed] for sician's orders transcribed for 5/22/12 failed to a for nitroglycerin as a pain. Ses Notes, dated 5/22/12 at failed, "Resident chest pain. MD notified. Sitrostat 0.4 mg sublingual [minutes] PRN, do not			are transcribed, accurate, and to date into resident current medical record. Skin assessments were completed DNS/Designee on 7/1/12 to ensure up to date and completed. Licensed Nursing staff will be re-educated on or by 7/3/12 or documentation, including the accuracy of completing assessments, as well as, documentation the assessment appropriately. Documentation must include the type of rash, size, location, and description be considered completed appropriately. Re-education various programs will occur on by 7/10/12 including: documentation guidelines, skir program, weekly skin assessments, and overview of skin management program. Non-compliance with these practices will result in further education including disciplinary action. Director of nursing services/designee is responsible to ensure compliance. What measures will be put into pla or what systemic changes with the deficient practice does not recur? An audit of physician orders and PRN medications reviewed by DNS/Designee to ensure documentation was complete and accurate. All ord will be reviewed daily by DNS/Charge nurse to ensure transcibed orders are accurate and complete. Skin	by te. to on or y ble tce iii	
		55 1 15 to 5, dated 5/25/12 dt	1		and complete. Only		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		155697	A. BUII			06/22/2012	,
		1.0000.	B. WIN			00/==/=0:=	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COM	IPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	12:43 p.m., indi	cated, "C/O			assessments were completed	by	
	[complained of]	chest pain this AM			DNS/Designee on 7/1/12 to		
	[morning]. PRN	I nitro X1 [times one			ensure up to date and comple		
	dose] was effect	-			Results of the skin assessment will be documented in the	ils	
	aosej was erreet				medical record by the		
	ъ	1 1: 4			DNS/Designee. Skin		
		was lacking on the			assessments documents will	oe l	
	Medication Adm	ninistration Record for			reviewed weekly to ensure		
	May 2012 that the	ne medication was			accurate and complete by		
	administered on	5/22/12 or 5/23/12.			DNS/Designee.Infection contr	ol	
					log will be updated as needed	by	
	During interview	v on 6/22/12 at 4:30 p.m.,			DNS/Designee. Licensed		
	_	•			Nursing staff will be re-educat	ed	
		rector of Nursing			on or by 7/3/12 on		
		ed the resident's physician			documentation, including the		
	may not have or	dered Nitrostat when the			accuracy of completing		
	nurse called him	to verify orders at the			assessments, as well as, documentation the assessme	nte	
	time of admission	on, since the medication			appropriately. Documentation		
	was not included				must include the type of rash,	'	
		rs. The ADON indicated			size, location, and description	to	
					be considered completed		
	-	y not the case though,			appropriately. Re-education	on	
	_	resident's diagnoses. She			various programs will occur of	n or	
	indicated the om	ission of the order was			by 7/10/12 including:		
	probably an over	rsight. She also indicated			documentation guidelines, ski	n	
	she was unable t	to determine from the			program, weekly skin	_	
		n the record if the			assessments, and overview of skin management program.	'	
		ministered on 5/22/12			Non-compliance with these		
					practices will result in further		
		ras obtained. She also			education including disciplinar	_v	
		ministration of the			action. · Director of nursing	·	
	Nitrostat on 5/23	3/12 was not documented			services/designee is responsi	ble	
	on the Medication	on Administration			to ensure compliance. How		
	Record.				the corrective action(s) will I	pe	
					monitored to ensure the		
	2 The clinical r	record for Resident E was			deficient practice will not red	cur,	
					i.e., what quality assurance		
		2/12 at 9:30 a.m.			program will be put into place	:e?	
	Physician teleph	one orders, dated			·To ensure compliance, the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155697		LDING		06/22/	/2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
CLADIC		AND SKILLED NUIDSING CENTER	,		ITTLE LEAGUE BLVD		
CLARK	REHABILITATION	AND SKILLED NURSING CENTER	· · · · · · · · · · · · · · · · · · ·	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	•	DATE
		ed the resident was to			DNS/Designee is responsible the completion of the skin	for	
		ping to rule out scabies,			management and MAR/TAR f	low	
	receive treatmen	nt with a scabicidal			sheet CQI tool weekly times 4		
	medication, and	I repeat the treatment in			weeks, bi-monthly times 2		
	seven days.				months, and then quarterly un	til	
					continued compliance is		
	The Weekly Sk	in Assessment, dated			maintained for 2 consecutive	_	
	_	ed the resident had a rash			quarters. The results of thes audits will be reviewed by the		
	"all over body."				committee overseen by the El		
	an over body.				threshold of 95% is not achiev		
	TI (337 11				an action plan will be develop		
		ly Skin Assessment, dated			to ensure compliance.		
	· ·	d the resident had "None					
	of the above" for	or Skin tears, Open areas,					
	Marks, Bruises,	Discoloration/Rashes,					
	Dry/cracked lip	s, or Dry mucous					
	membranes.						
	The next Weekl	ly Skin Assessment, dated					
		ed, "None of the above"					
		Open areas, Marks,					
	Bruises, Discolo	•					
		s, or Dry mucous					
	1	s, or Dry mucous					
	membranes.						
		D 37 . 0 . 1					
	1	Progress Note for the					
	same date as the						
	· · · · · · · · · · · · · · · · · · ·	18/12, included, but was					
	not limited to, "	She also has been					
	having a mild p	ruritic rash on her torso.					
	She is not sure l	how long it has been there					
		ust a recent thing within					
	_	two. She states it is					
		ner neck and upper back					
		e has been no relief for the					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155697		B. WING			06/22/2012			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
			_		ITTLE LEAGUE BLVD			
CLARK REHABILITATION AND SKILLED NURSING CENTER			₹	CLARK	SVILLE, IN 47129			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL DESCRIPTION OF LIST DEPOT OF THE PROPERTY OF T			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE	
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
TAG	past few weeks with over the counter			TAG	BELICERCE		DATE	
	1 *							
		this symptom is mild"						
	The Physician Exam portion of the							
	Progress Note indicated, "SkinWarm							
	and dry. She has a few solitary lesions on							
		nostly on the left side and						
	her neck as well that have scabbed over							
		coriations. She also has						
	some minimal erythematous minimal							
	raised areas as well in the same							
	vicinity"							
	3. The clinical record for Resident A was							
		2/12 at 9:45 a.m.						
		one orders, dated						
		ed the resident was to						
	·	ping to rule out scabies,						
		at with a scabicidal						
		repeat the treatment in						
	seven days.							
	Th. W. 11 C1:							
	I	n Assessments on the						
		indicated, "None of the						
		tears, Open areas, Marks,						
	Bruises, Discolo							
	_	s, or Dry mucous						
		5, 3/12, 3/13, 3/20, and						
	3/26/12.							
	1 The eliminal -	record for Resident C was						
		2/12 at 10:15 a.m. The						
		a Physician's Telephone						
	Order, dated 6/9/12, for "Contact isolation							
	X 48 hours." Th	ne "Care Plan Update"						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00			COMPLETED	
	155697		B. WIN	G		06/22/	2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
CLARK REHABILITATION AND SKILLED NURSING CENTER			,	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129				
			` <u> </u>		5 VILLE, IN 47 129			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	section of the Physician's Telephone							
		Order indicated, "Problem: rash."						
	Documentation in Resident Progress							
	Notes and on Weekly Skin Assessments failed to indicate a description of the rash.							
	During interview on 6/22/12 at 11:05							
	a.m., Resident C indicated she had a rash							
	that itched on her right side. She							
		ughter had looked at the						
	rash and told her it looked like little							
	pimples.							
		6100 H 0						
	During interview on 6/22/12 at 2:25 p.m.,							
		the Assistant Director of Nursing						
	, ,	(ADON) indicated when the facility has						
		an's orders for skin						
		scrapings related to possible scabies, she						
	has completed the skin scrapings. She							
	indicated the clinical record did not show							
	Resident A had a rash, but she saw the							
	rash when the skin scraping was completed. Subsequently the ADON							
	_	f a late entry for a Skin						
		For Resident A, dated for						
	3/20/12 and writ	*						
		and/skin condition type:						
		eralized rash; Describe						
	_	cm [centimeters]: small						
		ed rash back, chest, arms,						
	legs." The ADO	N also provided copy of						
	a late entry for S	kin Integrity Event for						
	Resident C, dated 6/9/12 and written 6/22/12, indicating, "Wound/skin							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 06/22/2012		
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE	
	cm [centimeters]	Rash; Site: Describe measurements in Rescribe measurements in						
	This federal tag IN00109996, INI	relates to Complaints 00110070, and						
	3.1-50(a)(1) 3.1-50(a)(2)							

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